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The Health and Social Care Act 2012: The emergence of equal treatment for mental health care or another false dawn?

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Abstract
Although the National Health Service (NHS) is regarded as a national treasure, it is no longer immune from the colossal financial pressures brought about by global recession. Economic sustainability has largely driven the reform process leading to the Health and Social Care Act (HSCA) 2012, however; other considerations have also played a role in the journey to turn the health and social care service into an institution which is fit for the 21st-century needs. This article examines the impact of the HSCA 2012 on those made vulnerable through mental ill health. It then considers three issues: First, whether parity between mental and physical health can have life beyond political rhetoric; second, what impact driving up efficiency within the NHS will have upon mental health patients; and finally, the extent to which the personalisation agenda can be meaningfully applied within the mental health context.

Keywords
Mental health, Health and Social Care Act 2012, parity, efficiency, personalisation

Introduction

Over the last 60 years, the National Health Service (NHS) has become an intrinsic feature of the United Kingdom, not only underpinning the nation's health but exemplifying some

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of its core values and beliefs that are still widely held today.[1] The NHS was founded upon three core principles: to meet the needs of everyone; to remain free at the point of delivery and that access to the NHS be based on clinical need, rather than ability to pay.[2] These principles remain a fundamental part of the NHS – yet as the years have passed, there is broad agreement that modernisation of the NHS has become a necessity.[3] With costs soaring and demand rising exponentially; with the need for improvements and technological developments remaining an unremitting drain on the NHS coffers and the current economic climate making protected, ring-fenced NHS budgets unsustainable in the years to come, proactive steps to reform the NHS have been taken in the shape of the Health and Social Care Act (HSCA) 2012.[4] Modernisation has been driven by the demands placed upon a 60-year-old health service provider. Yet the drive to take the health service into the 21st century and become an economically viable and sustainable endeavour has also highlighted another deep-seated problem within the NHS: How to ensure vulnerable groups are cared for effectively, particularly with shifting demographics. The focus of this article is that of the mentally ill, and it will consider how this group fares under the changes introduced by the HSCA 2012.

Prior to the enactment of the HSCA 2012, the needs associated with mental health conditions[5] had already been explicitly acknowledged as a priority.[6] Since then, a new mental health outcomes strategy was published in February 2011, *No Health Without*

1. For a detailed discussion of the creation and foundation of the NHS, see, N. Timmins, *The Five Giants: A Biography of the Welfare State* (London, UK: HarperCollins, 2001).
2. Available at: http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhscoreprinciples.aspx (accessed 2 August 2013). See also, T. Delamothe, 'Founding Principles', *British Medical Journal*, 336 (2008), p. 1216. For a more detailed consideration of the foundations of the NHS in 1948, see, M. Powell, 'Granny's Footsteps, Fractures and the Principles of the NHS', *Critical Social Policy* 16 (1996), p. 27.
3. For example, A.C. Enthoven, & M. Eccles, 'A Promising Start, But Fundamental Reform is Needed', *British Medical Journal* 320 (2000), pp. 1329–1331.
4. There is little doubt that the NHS is facing considerable challenges today. If the NHS '[was] . . . performing at world-class levels, the NHS could save 5,000 more lives from cancer, and 2,000 more lives from respiratory diseases each year. Our population is aging, while the cost of advances in treatments and medicines add around £600 million of funding pressure to the NHS budget every year', Department of Health, *Pausing, Listening, Reflecting, Improving*, Available at: http://healthandcare.dh.gov.uk/pausing-listening-reflecting-improving/ (accessed 20 August 2013).
5. Throughout this article the term 'mental health condition' is used to describe all mental disorders or illnesses that meet generally accepted criteria for clinical diagnosis.
6. See, Department of Health, *Modernising Health and Social Services: National Priorities Guidance 1999/00–2001/02* (London, UK: Department of Health, 1998); Department of Health, *Saving Lives: Our Healthier Nation*, Cm 4386 (London, UK: HMSO, 5 July 1999); Department of Health, *National Service Framework for Mental Health: Modern Standards and Service Models* (London, UK: TSO, 8 February 2007).

Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages,[7] followed by an implementation framework, published in July 2012.[8] The strategy aims to provide better mental health for all and to increase the number of people recovering from mental health conditions, whilst the implementation framework focuses on the provision of strong outcomes monitoring. These mental health objectives are expected to map onto the broader NHS changes under the HSCA 2012 by virtue of explicit recognition within the legislation that mental ill health will be given parity alongside other physical health needs.[9] The consolidation of these steps by the HSCA 2012 is fundamental in ensuring mental health conditions are effectively recognised and responded to.[10] Achieving this will not be easy in a climate where the global burden of disease is rising, and mental health and behavioural disorders in particular account for an increasing proportion of this.[11] Provision for the mentally ill has always been stretched, struggling under the weight of systemic neglect and a lack of resources. The vulnerable, whether the mentally ill, the elderly or those who are mentally incapacitated, are particularly at risk as they are often not in a position to protect their own rights. Instead, reliance is placed upon those around them and the systems they are placed within to do this for them.

In the wake of the HSCA 2012, it is necessary to reflect upon whether the 2012 Act offers hope to those made vulnerable through mental ill health, or whether it instead fails them, and if so, why? This article explores this question with reference to three key policy drivers within the legislation and is structured accordingly. In the first instance, the article examines the HSCA 2012 from the mental health perspective, in terms of how the restructured commissioning process operates and how it maps on to the mental health framework. Attention is then given to three issues: First, whether parity between mental

7. Department of Health, *No Health Without Mental Health A Cross-Government Mental Health Outcomes Strategy for People of All Ages* (London, UK: TSO, February 2011). Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf (accessed 2 August 2013).
8. See, Centre for Mental Health, Department of Health, Mind, NHS Confederation Mental Health Network, Rethink Mental Illness, Turning Point, *No Health Without Mental Health: Implementation Framework*, 24 July 2012. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/156084/No-Health-Without-Mental-Health-Implementation-Framework-Report-accessible-version.pdf.pdf (accessed 25 July 2013).
9. See, Department of Health, *The Mandate: A Mandate From the Government to the NHS Commissioning Board: April 2013 to March 2015* (London, UK: Department of Health, November 2012).
10. Different data sets highlight the need to recognise mental ill health as a fundamental concern, for example, see, N. Singleton, R. Bumpstead, M. O'Brien, A. Lee and H. Meltzer *Psychiatric Morbidity Among Adults Living in Private Households, 2000* (London, UK: TSO, 2001); Royal College of Psychiatrists, *Mental Health and Work* (London, UK: Royal College of Psychiatrists, 2008); S. McManus, H. Meltzer, T. Brugha, P. Bebbington and R. Jenkins, *Adult Psychiatric Morbidity in England 2007: Results of a Household Survey* (London, UK: National Centre for Social Research, 2009).
11. See, C. Murray, et al., 'UK Health Performance: Findings of the Global Burden of Disease Study 2010', *The Lancet*, 381(9871) (2013), pp. 997–1020.

and physical health can in all reality have life beyond political rhetoric; second, what impact driving up efficiency within the NHS, in terms of commissioning decisions, will have upon patients with mental health conditions and third, the extent to which the personalisation agenda can be meaningfully applied within the mental health context. These issues are considered with reference to broader policy influences within the mental health law and policy landscape.

The HSCA 2012 – the mental health perspective

Whilst the fundamental restructuring of the NHS has been the subject of recent attention with the enactment of the HSCA 2012, mental health has also been under the spotlight of reform in the past few years. The Mental Health Act 2007[12] sought to respond to the challenges posed by changing psychiatric practices and the policy shift from hospital-based treatment to care in the community.[13] Over the last two decades, reliance on hospital-based care has diminished and has been replaced by the community as the dominant care environment. Hospital care is now reserved largely for those requiring acute or intensive psychiatric care.[14] To some extent resources have followed this changing pattern of care, but inevitably, service provision and delivery has been affected by the gradual shift in the mental health landscape.[15]

In parallel with the introduction of the Mental Health Act 2007, modifications have been made to the Mental Health Act *Code of Practice* to reflect the legislative amendments. Whilst the Code is not legally binding, decision-makers are required to justify any departures from its guidance in their decision-making.[16] The amended Code features principles which are designed to promote patients' interests and guide decision-

12. See, Report of the Expert Committee, *Review of the Mental Health Act 1983* (London, UK: Department of Health, 1999); HM Government, *Reforming the Mental Health Act: Part I: The New Legal Framework* (London, UK: TSO, 2000), Cm 5016-I; see also, J.M. Laing, 'Rights Versus Risk? Reform of the Mental Health Act 1983' *Medical Law Review* 8(2) (2000), pp. 210–250; J. Peay, 'Reform of the Mental Health Act 1983: Squandering and Opportunity?', *Journal of Mental Health Law* 3 (2000), pp. 5–15.
13. D. Pilgrim, 'New 'Mental Health' Legislation for England and Wales: Some Aspects of Consensus and Conflict', *Journal of Social Policy* 36(1) (2007), pp. 79–95.
14. Inpatient facilities are now often not a place for therapeutic intervention, but instead are 'crisis stabilisation centres', see, A. Hill, 'Mental Health Services in Crisis Over Staff Shortages: **Exclusive**: Royal College of Psychiatrists Warns Society will be Overwhelmed if Ministers Fail to Fill Gap', *The Guardian*, Monday 20 June 2011.
15. G. Thornicroft and M. Tansella, 'Components of a Modern Mental Health Service: A Pragmatic Balance of Community and Hospital Care. Overview of Systematic Evidence', *The British Journal of Psychiatry* 185 (2004), pp. 283–290; P. Tyrer and S. Johnson, 'Has the Closure of Psychiatric Beds Gone Too Far? Yes', British Medical Journal 343 (2011), p. d7457; G. Thornicrift and M. Tansella, 'The Balanced Care Model: The Case for Both Hospital and Community-Based Mental Healthcare', *The British Journal of Psychiatry* 202 (2013), pp. 246–248.
16. *R (Munjaz) v Mersey Care NHS Trust* [2005] UKHL 58.

making under the Act.[17] These principles are first, the purpose principle, whereby decisions under the Act must be made to minimise the undesirable effects of mental disorder; second, the least restriction principle, where decision-makers should keep to a minimum the restrictions they impose on the patient's liberty; third, the respect principle, whereby recognition and respect should be given to the diverse needs, values and circumstances of each patient; fourth, the participation principle that encourages patients' involvement and finally, the effectiveness, efficiency and equity principle that focuses upon optimal decision-making using available resources in the most efficient way possible.[18] In many ways, the essence of these principles can also be found within the HSCA 2012. However, whilst these principles promote universally recognised values and provide an opportunity to foster better care, their literal interpretation may not always 'fit' the actual process of implementation. It is often here where the legislative framework fails the mentally vulnerable. Ineffective implementation of core values within both 'hard' and 'soft' legal instruments is, perhaps, the largest source of damage for vulnerable groups and will be reflected upon throughout this article.

The HSCA 2012 has been heralded as the most extensive and radical reorganisation of the NHS to date[19] and has been accompanied by significant levels of political rhetoric, speculation and controversy.[20] The legislation had two key objectives: To improve the quality of care and outcomes for patients and to reposition the mode of provision so that health service provision becomes more patient-centred and facilitates choice. These objectives are incontrovertible; however, many of the mechanisms that the legislation introduces to achieve these aims have generated concern amongst service users, clinicians and service providers alike. The changes introduced by the Act are far reaching and for those with chronic and enduring conditions, of which all mental health conditions would likely be labelled, the HSCA 2012 can be expected to wield significant weight in treatment and care planning as it becomes fully operational in the months to come.

17. In 1998, the Richardson Committee proposed that the new mental health legislation should be rooted in legislative principles, see, Report of the Expert Committee, *Review of the Mental Health Act 1983* (London, UK: Department of Health, 1999). Instead, the guiding principles can be found in the *Code of Practice*, instead of on the face of the Mental Health Act 2007 (see, House of Lords, House of Commons Joint Pre-Parliamentary Scrutiny Committee Report on the Draft Mental Health Bill (HL Paper 79(1), HC Paper 95(1), Session 2004–2005, at para 64. For an in-depth discussion, see, P. Fennell *Mental Health: The New Law* (Bristol: Jordans Publishing, 2007), p. 37.
18. Department of Health, *Code of Practice: Mental Health Act 1983* (London, UK: The Stationery Office, 2008) at paras 1.2–1.6.
19. By July 2010, the White Paper, *Equity and Excellence: Liberating the NHS*, Cm. 7881, was published. Although progress of the Health and Social Care Bill was slowed with a 'listening exercise' between April and May 2011 for the Government to hear and take account of concerns raised about the Bill, the Bill received Royal Assent on the 27 March 2012.
20. N. Timmins, *Never Again? The Story of the Health and Social Care Act 2012: A Study in Coalition Government and Policy Making* (London, UK: The King's Fund and the Institute for Government, 2012). See also, R. Taylor, *God Bless the NHS* (London, UK: Faber & Faber, 2013).

Several key elements of the legislation guide its implementation: ensuring a patient-centred NHS; promoting and supporting a clinician-led service and transferring the emphasis of measurement to clinical outcomes.[21] However, it is conceivable that these principles have the potential to conflict with significant consequences and may have lasting implications upon the quality of delivered care. The question remains whether any one of these principles will dominate during the implementation process, and if so, which it will be. The persistent concern amongst many professional and user groups[22] alike has been and continues to be that the political desire to make financial savings and improve the cost-effectiveness of the NHS may prove to be the overarching driver.[23] A related concern is that the legislation represents an inevitable shift away from the ideology of universal provision, a mainstay of the old NHS,[24] towards a stronger endorsement of expanding private sector involvement and a gradual privatisation of the health service.[25] The reinforcement of competition principles within the health care system is likely to have a detrimental impact on the mentally vulnerable as the Act opens up private sector involvement, making the process of commissioning outside of the NHS structure easier and more cost-effective. In all likelihood, this will encourage providers to be more active in lucrative areas of health care. Mental health care and associated social care provision is generally seen as an unprofitable field, with long-term and often complex care and support required by individuals. The 2012 Act's market-based approach may prove to be particularly damaging for the mentally ill, with resources being allocated away from the needs of this group and short-term care measures, such as acute inpatient provision, being given greater attention than the longer term health and social care needs of individuals in the community. The Act also introduces a change to one of the central NHS tenets:[26] No longer will services be exclusively operated via the NHS and its partners; instead, 'any willing provider' could supply services. This enables the private sector to have direct access to the central operations of the NHS, in terms of both planning and provision. Although this allows for 'any willing provider' and thus goes beyond the private sector, social enterprises may find it difficult to compete against organisations in the

21. See, Department of Health, *Equity and Excellence: Liberating the NHS*, Cm. 7881 (London, UK: TSO, 2010).
22. See, D. Redding, 'NHS Reforms: What do They Mean for Patients?' *Guardian Professional*, Tuesday 3 April 2012.
23. Exponential spending on the NHS has occurred since it was established in 1948. In 2010/11, government expenditure was £121bn, see, R. Harker, *NHS Funding and Expenditure* (London, UK: House of Commons Library, SN/SG/724, 3 April 2012). See also, C. Naylor, M. Parsonage, D. McDaid, M. Knapp, M. Fossey and A. Galea, *Long-Term Conditions and Mental Health. The Cost of Co-morbidities* (London, UK: The King's Fund, 2012).
24. E. Speed and J. Gabe, 'The Health and Social Care Act for England 2012: The Extension of 'New Professionalism'', *Critical Social Policy* 33(3) (2013), pp. 564–574.
25. Currently, it is estimated that £1 of every £20 spent in the NHS goes to a non-NHS provider, see, Q&A: The *NHS Shake-Up*, 1 March 2013, Available at: http://www.bbc.co.uk/news/health-12177084 (accessed 25 July 2013).
26. R. Page, 'The Attack on the British Welfare State-More Real Than Imagined? A Leveller's Tale', *Critical Social Policy* 15(44–45) (1995), pp. 220–228.

private sector who can afford to undercut in the race to acquire a commissioning contract.[27] Currently, the role of third sector organisations in mental health care is much more prominent and is, indeed, essential, particularly in relation to social care provision; however, whether this will continue remains open to speculation.[28] If third sector organisations do struggle in this new provider landscape, the mentally ill will inevitably suffer as the tailored, personal provision currently offered by many small organisations and charities is likely to be curtailed as they battle to compete.[29]

Commissioning of services for mental health care and treatment services will be conducted and guided by Clinical Commissioning Groups (CCGs),[30] which are introduced by the HSCA 2012, in a similar fashion as for all other services. The guiding principles[31] under the HSCA 2012 will be influential in how CCGs conduct their activities. In the first instance, CCGs have a duty to promote the NHS Constitution[32] and ensure patients, staff and the public are aware of the NHS Constitution and their NHS constitutional rights. CCGs will also have a general duty to improve the quality of the services they provide or commission. Primary medical services (which include acute inpatient psychiatric care and secure psychiatric units) are to be commissioned by NHS England. The focus on quality improvement goes beyond the old duty that primary care trusts (PCTs) had under NHS Act 2006, which was to improve the quality of health care services apropos existing published standards. Instead, the duty under the HSCA 2012 explicitly recognises the need to consider treatment and care outcomes and the patient experience. CCGs are also required to endorse a patient-centred approach[33] by encouraging patient

27. N. Curry, C. Mundle, F. Sheil and L. Weaks, *The Voluntary and Community Sector in Health: Implications of the Proposed NHS Reforms* (London, UK: The King's Fund, 2011).
28. N. Glover Thomas and W. Barr, 'Re-Examining the Benefits of Charitable Involvement in Housing the Mentally Vulnerable', *Northern Ireland Legal Quarterly* 59(2) (2008), pp. 177–200; N. Glover Thomas and W. Barr, 'Enabling or Disabling? Increasing Involvement of Charities in Social Housing', *The Conveyancer and Property Lawyer* 3 (2009), pp. 209–235.
29. Opening up markets creates considerable barriers to market entry by social enterprises as high capital costs can often only be found by large providers. As social enterprises are usually quite small (and so, there is a greater risk of failure to deliver the contract owing to shortages of funds) and there is no longer preferential treatment given to social enterprises, it is likely that in the health sector where social enterprises are competing with large NHS providers and private organisations, their involvement may diminish. See further, M. Brown and D. Floyd, *Better Mental Health in a Bigger Society?* (London, UK: The Mental Health Providers Forum, 2011).
30. CCGs are clinically led groups that include all of the general practitioner (GP) groups in their geographical area and have the aim of giving GPs and other clinicians the power to influence commissioning decisions for their patients.
31. Same as fn 19.
32. Section 3 of the Health and Social Care Act 2012 inserts a new section 1B into the NHS Act 2006, placing a duty on the Secretary of State to have regard to the NHS Constitution. Section 14P imposes a duty upon CCGs both to act in the exercise of its functions with a view to ensuring health services are provided in a way that promotes the NHS Constitution.
33. For a broader discussion, see A. Coulter, 'Do Patients Want a Choice and Does it Work?', *British Medical Journal* 341 (2010), p. c4989; Care Quality Commission, *National NHS*

involvement through shared decision-making. The implementation of this duty will be facilitated by new guidance to be published by NHS England.[34] As part of the focus upon patient-centred provision, CCGs will now also have to operate with a view to commissioning services from more than one provider as the 2012 Act also introduces a duty to enable patient choice.

How viable the balancing exercise of enabling patient choice within the mental health field will be remains to be seen. The creation of patient choice relies not only upon CCG behaviour endorsing and facilitating patient choice, but the providers of these services must actually exist – in mental health, the fulfilment of identified need has often presented challenges, as service provider limitations are routine. At a broader level, concern surrounds the impact this duty to facilitate patient choice may have on the market.[35] Encouraging CCGs to commission several alternative treatments from different providers may lead to more providers having a smaller market share and greater fragmentation within the health and social care service sector might result.[36] Quite how the commissioning process can effectively achieve efficiency through competition whilst also increasing patient choice is difficult to understand; or at least, it is possible to foresee challenges and tensions developing in the attainment of this aim. Patient choice is often determined through a plethora of motivating factors, not least the common desire to be close to family and friends. For many, access to psychological services is a central wish, with drug therapy being a necessity of last resort. However, as we will see later in this article, drug therapy is often deemed to offer a front-line response to patients' mental health needs by general practitioners (GPs), and psychological services are limited in availability.[37] CCGs will be restricted by these practical limitations, but they will also be under a duty to ensure service commissioning is subject to tender under the National Health Service (Procurement, Patient Choice and Competition) Regulations 2013.[38] If the framework of health and social care does crumble under the weight of these different legislative objectives, those with mental health conditions may be particularly vulnerable as a fragmented health and social care service will not be beneficial to them. Additional choice may inevitably be at the expense of effective integration.

Despite this, under the 2012 Act, CCGs have a duty to promote service integration. This entails the integration of health services with health-related and social care services.

Patient Survey Programme: Survey of Adult Inpatients 2010; Survey of Adult Outpatients 2009; Maternity Survey 2010; Survey of Local Health Services 2008. Available at: www.nhssurveys.org (accessed 31 August 2013); N. Richards and A. Coulter, *Is the NHS Becoming More Patient-Centred?* (London, UK: Picker Institute Europe, Department of Health, 2007).

34. NHS England, *Developing the NHS Commissioning Board* (London, UK: TSO, 2011), p. 9.
35. The National Health Service (Procurement, Patient Choice and Competition) Regulations 2013, No. 257, impose a requirement on the NHS Commissioning Board and clinical commissioning groups to protect patients' rights to make choices and to prevent anti-competitive behaviour.
36. Care Quality Commission, *The State of Health Care and Adult Social Care in England in 2011/12* (London, UK: TSO, 2012).
37. Cf. fn 64.
38. Same as fn. 35.

The political motivation behind this duty is to improve efficiency of service provision and to reduce unnecessary costs. Nonetheless, from the patient perspective, this offers an avenue for improvements in quality of life, particularly for those who need longer term support in the community. For the mentally vulnerable, effective integration of services is often particularly important, improving the implementation of treatment plans, medication compliance and ongoing community-based support. The difficulty with this duty is that as yet no guidance has been supplied to aid CCGs in the process of achieving good integration amongst and between these various services. Furthermore, mental health provision is littered with countless examples of joint working failures and inadequate communication throughout the health and social care system. Indeed, the ideal of achieving seamless provision is far removed from the reality for many patients, and it is often this which leads to the disjointed care that is received[39] and the gaps in provision where patients fall through the net.

The required establishment of Health and Wellbeing Boards[40] by each local authority may reduce the perennial problems surrounding joint working.[41] Collaboration between the Board members will afford the opportunity to assess local health and social care needs, agree on spending priorities and encourage CCGs to work with seamless, joined up provision in mind. Boards can extend their membership to reflect particular area needs; this may allow a local service to be developed for local needs. The Board is also required to take account of affiliated services with social care, such as, housing and education and to recognise that these services have a direct influence on the broader well-being of individuals. It is uncertain whether this will directly improve service provision, but the Cross-Government Mental Health Strategy[42] pins its hopes on the shift towards localism and local care decision-making under the 2012 Act. The Mental Health Strategy Implementation Framework[43] suggests that it is this focus on local needs which 'can deliver the vision of improved mental health and wellbeing'.[44]

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39. C. Ham and N. Walsh, *Making Integrated Care Happen. Lessons From Experience* (London, UK: The King's Fund, 2013).
40. These Boards will take on their statutory functions from April 2013. See, Department of Health *A Short Guide to Health and Wellbeing Boards*. Available at: http://healthandcare.dh.gov.uk/hwb-guide/ (accessed 28 February 2012).
41. R. Humphries, A. Galea, L. Sonola and C. Mundle, *Health and Wellbeing Boards: System Leaders or Talking Shops?* (London, UK: The King's Fund, 2012).
42. See, N. Glover Thomas, 'Joint Working; Reality or Rhetoric in Housing the Mentally Vulnerable?' *Journal of Social Welfare and Family Law* 29(3–4) (2007), p. 217.
43. Centre for Mental Health, Department of Health, Mind, NHS Confederation Mental Health Network, Rethink Mental Illness, Turning Point *No Health Without Mental Health: Implementation Framework.* Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/156084/No-Health-Without-Mental-Health-Implementation-Framework-Report-accessible-version.pdf. Briefing paper available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/137645/No-Health-Without-Mental-Health-Implementation-Framework-Report-accessible-version.pdf.
44. 'Centre for Mental Health, Department of Health' p. 5.

The restructuring of the NHS and the changes created by the HSCA 2012 to the commissioning process will take time to grow accustomed to. From a mental health perspective, the HSCA 2012 offers real potential to see mental health brought from the margins of provision to feature much more prominently. It creates the possibility for a conceptual reconfiguration of health to emerge, introducing explicitly the need for parity between mental and physical health. Indeed, this duty to promote health parity could create the impetus for a paradigmatic shift within health and social care provision, but just how successful the implementation of this will be remains to be seen as the high-level commitment to health parity is only one of several key objectives within the 2012 legislation. Devolution of budgets down to CCGs may provide opportunities for mental health to feature more prominently within the commissioning process; yet there are concerns that mental health needs may continue to be overlooked by CCGs when pressure to commission services efficiently whilst also increasing patient choice presents significant tensions for CCGs to overcome.

We will now turn to consider three drivers within the 2012 Act, exploring whether they are feasible within the mental health context or whether the legislation will prove to be detrimental to those with mental health needs. First, attention will be given to the commitment to achieving parity of physical and mental health within the health care system, followed by a consideration of how the desire to increase efficiency may influence commissioning decisions within the mental health arena and finally, consideration will be given to the move towards expanding patient choice and personalisation within the health care market.

Parity between mental and physical health in the commissioning process: More than political rhetoric?

The Government's draft mandate to NHS England is explicit in its message: Direct recognition is to be given to the need to place mental health on the same footing as physical health.[45] This is a significant step forward and should be welcomed. Mental health conditions are now to be recognised as a clear equality issue[46] and the NHS Equality

45. The first NHS Mandate was published on 13 November 2012. It sets out the Government's ambitions for the health service until 2014 and reaffirms its commitment to an NHS that remains comprehensive and universal. Available at: http://mandate.dh.gov.uk/

46. An integral principle running through *No Health Without Mental Health: Implementation Framework*, is the acknowledgement that groups protected by the Equality Act 2010 need to be identified and protected. These groups are defined by the characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation. Parity of physical and mental health has been formally recognised as an important objective within health provision for many years prior to the HSCA 2012. This was acknowledged in the House of Lords Committee Stage debate where Baroness Hollins (Crossbench) moved an amendment to replace the word 'illness' within the Health and Social Care Bill with the words 'physical and mental illness'. Lord Howe noted that the term illness is defined in Section 275 of the National

Delivery System[47] will be primed to help those providing NHS services to respond properly to it.[48] Perhaps of greatest importance is the Government's recognition in the Mental Health Implementation Framework[49] that achieving parity between physical and mental health is an absolute goal,[50] where more still needs to be done to ensure all organisations (both public and private) 'meet their equality and inequality obligations in relation to mental health'.[51] Steps are being taken to create a framework to measure outcomes and overall progress within mental health,[52] so that improvement strategies can be created and implemented when clear underperformance is identified.

Clearly, making improvements for mental health provision is dependent upon good implementation. CCGs will be expected to demonstrate to NHS England that they have sufficient planned capacity and an ability to commission for improved health outcomes in mental health. Owing to this shift in attitude, and indeed, reconfiguration of the conception of health within the legislation, the neglected and under-resourced mental health service may be a thing of the past. The drive to improve access to psychological therapies for patients with mental health conditions is an example of this attitudinal shift and is a welcome move.[53] The rhetoric of achieving parity between mental and physical health is,

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Health Service Act 2006 as including mental disorder within the meaning of the Mental Health Act 1983. He went on to note that 'references to the prevention, diagnosis and treatment of illness would already apply to both physical and mental illnesses without the need for those additional words' (HL Hansard, 2 November 2011, col 1293).

47. The Equality Delivery System for the NHS was introduced in August 2011.
48. NHS services must explicitly consider the particular needs of the most vulnerable groups, and within this, mental health needs must be directly responded to.
49. Centre for Mental Health, Department of Health, Mind, NHS Confederation Mental Health Network, Rethink Mental Illness, Turning Point *No Health Without Mental Health: Implementation Framework*. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/156084/No-Health-Without-Mental-Health-Implementation-Framework-Report-accessible-version.pdf. Briefing paper available at: http://www.nhsconfed.org/Publications/Documents/mhn-briefing-247.pdf (accessed 17 January 2014).
50. Section 1 Health and Social Care Act 2012 emphasises the importance of mental health alongside physical health as it amends Section 1 of the NHS Act 2006, which contains the Secretary of State's duty to promote a comprehensive health service designed to secure improvement in the physical and mental health of the people of England, and in the prevention, diagnosis and treatment of mental and physical illness.
51. 'Health and Social Care Act' fn 49, p 8.
52. 'Health and Social Care Act' fn 49. The mental health framework introduces a new mental health dashboard, which will provide a picture of overall progress towards implementing the mental health strategy.
53. *Improving Access to Psychological Therapies* (IAPT) is an NHS programme being rolled out across England offering interventions approved by the National Institute of Health and Clinical Excellence (NICE) for treating people with depression and anxiety disorders. The programme's second phase is marked by the publication of *Talking Therapies: a four year plan of action* in February 2011. The plan aims to expand the scope of the programme to other groups, including, children and young people, people with long-term physical conditions and medically unexplained symptoms or severe mental illness. In the 2010 Spending

in many ways, politically driven, though the evidence suggests that greater effort to improve mental health is needed; mental ill health is a leading cause of suffering, economic loss and social problems and accounts for over 15% of the disease burden in developed countries.[54] In the European Union at least 83 million people (27%) suffer from mental health problems (16.7 million in the United Kingdom),[55] with depression being the most common (8–12% of the adult population).[56]

The newly restructured system of health and social care is in its infancy, and it is still too early to say whether the steps taken to achieve parity will bear fruit. Likewise, how the vulnerable will be able to protect their rights in this new health and social care environment is unknown, but it seems likely that CCGs, if motivated by market-driven policies, could lose sight of the particular needs of these vulnerable groups. In many ways, achieving parity is a deep-seated cultural issue and goes far deeper than surface-level implementation. Achieving parity needs fundamental attitudinal change at institutional, organisational and individual levels. For mental health, the best hope for this change exists within the Mental Health Implementation Framework[57] where explicit mention is made of the need to promote research into mental health and to recognise, support and strengthen academic career paths in this field.[58] It is only by consolidating capacity, instilling aspiration and professional motivation within the mental health care framework (both research and practice pathways) that the cultural transformation can begin to emerge.

Efficiency: The impact on mental health patients

Whilst parity of mental and physical health is a clear commitment within the HSCA 2012, the introduction of competition principles will also facilitate efficiency savings. Mental health needs are often complex, requiring the input of a variety of different agencies and service providers. Not only can providing for this complex diet of needs be

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Review, the Government committed an additional £400 million over the next 4 years to 2014/15, and confirmed support for the IAPT programme, which was originally launched in October 2008.

54. M. Prince, V. Patel, S. Saxena, M. Maj, J. Maselko, M. Phillips and A. Rahman. 'No Health Without Mental Health', *Lancet* 370 (2007), pp. 859–877.
55. H. Wittchen and F. Jacobi, 'Size and Burden of Mental Disorders in Europe: A Critical Appraisal of 27 Studies', *European Neuropsychopharmacology* 15(14) (2005), pp. 357–376.
56. T. Ustun, J. Ayuso–Mateos, S. Chatterji, C. Mathers and C. Murray, 'Global Burden of Depressive Disorders in the Year 2000', *British Journal of Psychiatry* 184 (2004), pp. 386–392.
57. Centre for Mental Health, Department of Health, Mind, NHS Confederation Mental Health Network, Rethink Mental Illness, Turning Point, *No Health Without Mental Health: Implementation Framework*, 24 July 2012. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/156084/No-Health-Without-Mental-Health-Implementation-Framework-Report-accessible-version.pdf (accessed 17 January 2014).
58. E. Cyhlarova, A. McCulloch, P. McGuffin and T. Wykes, *Economic Burden of Mental Illness Cannot be Tackled Without Research Investment* (London, UK: Mental Health Foundation, 2010).

difficult, it can be expensive. Both the cost and complexity of provision in mental health has been a persistent source of difficulty in the past and where tragic failures in care have occurred; investigations have often presented a catalogue of challenges surrounding the coordination and adequate funding of care.[59] Inevitably, establishing and identifying patient need and having the resources in place to meet it are not always achievable, and it is at this point that these system failures have often occurred.[60] The mental health care framework has very limited scope to be able to deal with increases in demand, and, traditionally, this is where the third sector has often been sought to plug the gap.[61] It is quite possible that without any form of overarching regional oversight, a task that PCTs undertook prior to the 2012 Act, the commissioning process may become fragmented and uncoordinated, and ultimately, gaps in some areas may be difficult to fill as patient needs may not be recognised in the round.[62]

Two separate issues in the commissioning process for mental health services exist: First, the level of clinical expertise that exists and second, whether CCGs have sufficient management experience to meet the need for equal distribution and coverage of services. These two areas raise doubts about how efficient and effective commissioning decisions will be carried out. In the first instance, there are doubts concerning GPs' broad clinical knowledge and expertise to identify and evaluate patient mental health needs. For many

59. J. Ritchie, *The Report of the Inquiry Into the Care and Treatment of Christopher Clunis* (London, UK: Stationary Office, 1994); J. Coid, 'The Christopher Clunis Enquiry', *Psychiatric Bulletin* 18 (1994), pp. 449–452. See also, J. Manthorpe and N. Stanley, *The Age of the Inquiry: Learning and Blaming in Health and Social Care* (Oxford, UK: Routledge, 2004), chapter 7; N. Glover Thomas, 'Joint Working; Reality or Rhetoric in Housing the Mentally Vulnerable?', *Journal of Social Welfare and Family Law*, 29(3–4) (2007), pp. 217–233 and N. Glover-Thomas, *An Investigation into Initial Institutional and Individual Responses to the Mental Health Act 2007: Its Impact on Perceived Patient Risk Profiles and Responding Decision-Making*, Mersey Care NHS Trust Final Research Report, March 2011, pp. 1–158.

60. For example, the National Inquiry found in July 2013 that there were '1,508 suicides in patients under crisis resolution/home treatment teams (CR/HT), 12% of the total sample, an average of 137 deaths per year. Since 2006, there have been 150-200 suicides per year under CR/HT'. It was also noted that 'since 2006 there have been more patient suicides under CR/HT than in in-patient care, *reflecting a change in the nature of acute care* [my emphasis]. In the last 3 years over twice as many suicides have occurred under CR/HT'; see, L. Appleby, N. Kapur, J. Shaw, I.M. Hunt, D. While, S. Flynn, K. Windfuhr and A. Williams. *The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report: England, Northern Ireland, Scotland and Wales* (Manchester, UK: National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Centre for Mental Health and Risk, July 2013), p. 31.

61. N. Glover Thomas and W. Barr, 'Re-examining the Benefits of Charitable Involvement in Housing the Mentally Vulnerable, *Northern Ireland Legal Quarterly* 59(2) (2008), pp. 177–200; N. Glover Thomas and W. Barr, 'Enabling or Disabling? Increasing Involvement of Charities in Social Housing', *The Conveyancer and Property Lawyer* 3 (2009), pp. 209–235.

62. R. Millar, I. Snelling and H. Brown, *Liberating the NHS: Orders of Change?* Policy paper 11, Birmingham, UK: Health Services Management Centre, University of Birmingham, 2011.

GPs, the initial response to patients presenting with mid to mild mental health conditions is to prescribe medication, rather than 'approach treatment holistically and refer patients to psychological therapies, peer-to-peer support networks or community-based services'.[63] GPs often rely heavily upon drug therapy as the first response to symptomatic presentation in patients,[64] which adds to the sense that GPs lack the depth of knowledge necessary. This is supported by recent research which reported that 30% of patients found their GP was unaware of services to support mental health recovery beyond medication.[65] Second, it is predicted that CCGs may have inadequate management expertise and from this, optimal commissioning decisions will be less likely to occur.[66] Given the sheer scale of care and social support needs that patients with mental health conditions often need, if CCGs lack membership that reflects the level of experience needed to recognise this, adequate mental health care provision is likely to be inadequate.

If pockets of poor management do emerge,[67] then mental health provision may be adversely affected. Often mental health provision is not the focus, with greater attention being given to physical health needs; yet mental health conditions account for 23% of the total burden of disease; but in terms of NHS expenditure, only 13% of health expenditure is currently directed towards psychiatric and related services.[68] Such underinvestment is not new and despite funds being channelled through PCTs at a regional level to recognised areas of need prior to the HSCA 2012, resource shortfalls have been commonplace. Mental health did not gain the moniker of the 'Cinderella' service without good reason and has been struggling under the weight of systemic neglect for a considerable time.[69] Unfortunately, mental health care must compete with all other health and social care needs, of which most are far

63. All Party Parliamentary Group on Mental Health, *Health and Social Care Reform: Making it work for mental health*, 2011, p 8. Available at: http://www.mind.org.uk/assets/0001/8974/APPGMH_Report_Health_and_Social_Care_Reform_Making_it_work_for_Mental_Health.pdf (accessed 25 July 2013).
64. For example, 'GPs prescribe soaring numbers of drugs for depression', *The Telegraph*, Thursday 09 May 2013; Spence, D, 'Are antidepressants overprescribed? Yes', *British Medical Journal*, 2013, p. 346.
65. In an unpublished survey conducted by Mind in May 2011, of 1,237 mental health service users, 358 (28.9 per cent) of participants reported that their GP was unaware of services to support mental health recovery. Available at: http://www.mind.org.uk/news/5247_as_gps_leave_mental_health_patients_in_the_dark_mind_hits_the_road_to_champion_local_services#research (accessed 25 July 2013).
66. A. O'Dowd, 'GP Consortiums Will Need First Class Management Support, says Nuffield Trust', British Medical Journal 342 (2011), p. 342. Available at: http://www.bmj.com/content/342/bmj.d337 (accessed 17 January 2014).
67. Care Quality Commission, *The State of Health Care and Adult Social Care in England in 2011/12* (London, UK: TSO, 2012).
68. The Centre for Economic Performance's Mental Health Policy Group, *How Mental Illness Loses Out in the NHS* (London, UK: Mental Health Policy Group, 2012).
69. For in interesting discussion, see, J. Adams, *'Challenge and Change in a Cinderella Service': A History of Fulbourn Hospital, Cambridgeshire, 1953–1995,* PhD thesis, The Open University, 2009.

more evident and have a more tangible quality about them. Whether the HSCA 2012 will improve this is uncertain. Management inadequacies and failures to identify needs by CCGs may not be detected as there remains some doubt about how the new NHS structure and regulatory bodies will scrutinize and oversee activities. The organisational reconfiguration reflects the mood of the Government to reduce bureaucracy and complexity in the health and social care framework, to improve efficiency and to redeploy functions through bodies that are independent or at least operating at arm's length of the Government.[70] Time will tell how these national bodies will work together in practice though as 'it is ... [just not yet] ... clear how these national bodies will interact or how they will provide coordinated and consistent governance of the NHS'.[71]

The challenges facing CCGs are unlikely to reassure patients in the short term; for mental health patients, these concerns may simply be more acute, given the complexity of typical mental health care needs which tend to stretch over a number of agencies and providers, often featuring periods of both acute need and stable chronicity. The standard and effectiveness of care received will all too often depend upon a strong framework of planned and integrated systems or pathways of care from a well-coordinated network of providers. CCGs are going to have to ensure sufficient awareness is present within the strategic planning process to take account of this, and if they do not, health conditions, including most mental health conditions, that require a complex health and social care response may suffer. The position of the already vulnerable could simply be compromised further.

Personalisation: Mapping the agenda on to the mental health framework

Personalisation is a central tenet of the restructured NHS. It refers to a social care approach where every person in need of care and treatment will have 'choice and control over the shape of that support in all care settings'.[72] Personalisation is characterised by shifting the power dynamic within the provider–user relationship. Greater emphasis is placed upon self-directed support and personal budgetary control combined with a move away from the notion that provision should follow a 'one-size-fits-all' approach.[73]

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70. See, Department of Health, *Liberating the NHS: Report of the Arm's- length body review* (July 2010) Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117691 (accessed 3 August 2013).
71. K. Walshe & C. Ham, 'Can the Government's Proposals for NHS Reform be Made to Work?', *British Medical Journal* 342 (2011), p. d2038.
72. J. Dunning, 'Expert Guide to Personalisation', *Community Care*. Available at: http://www.communitycare.co.uk/articles/25/07/2012/109083/personalisation.htm (accessed 25 July 2012).
73. A personal budget focuses upon providing ongoing social care support. See, Association of Directors of Adult Social Services *Making Progress with Putting People First: Self- Directed Support* (London, UK: DH/ADASS/IDeA/LGA, 2009a).

The personalisation agenda seeks to move the health and social care framework away from crisis management,[74] relying upon patients identifying personal needs and making appropriate care choices to meet these needs.[75] For this to be possible, adequate information and transparency within the system is essential. To implement the personalisation agenda, the social care system, in particular, will need to be sufficiently capacious to enable patient choice to be fully achievable. This means that CCGs have to take seriously the need to make and implement local commissioning decisions in a way that will enable genuine choices to be made. Commissioning will need to be multilayered and from a variety of providers; it will need to be possible to manipulate services so that tailor-made packages of care can be created for individual patients. In addition to the actual availability of services, steps must be taken to facilitate patients in the decision-making process. All patients, irrespective of age, capacity or support needs, should be aided as far as possible to ensure treatment and care choices are modified and are reflective of the patient's wishes.[76]

Within mental health, the essence of personalisation has been grounded in the mental health 'recovery approach'.[77] This approach is focused upon the mental health patient being afforded the opportunity to determine his own life and to be offered the support required to be able to live as independently as possible.[78] Some patients with mental health conditions have already experienced personalisation. For some time,[79] self-directed support has been an operational feature of care in the community. The idea is founded upon flexibility, choice and control of social care funding and focuses upon giving eligible people an annual budget to spend on their own care,[80] based upon self-

74. Department of Health, *Caring for Our Future: Reforming Care and Support*, Cm 8378 (London, UK: TSO, 2012).
75. R. Forster and J. Gabe, 'Voice or Choice? Patient and Public Involvement in the National Health Service in England under New Labour', *International Journal of Health Services* 38(2) (2008), pp. 333–356. See also, M. Fotaki, M. Roland, A. Boyd, R. McDonald, R. Scheaff and L. Smith, 'What Benefits Will Choice Bring to Patients? Literature Review and Assessment of Implications', *Journal of Health Services Research & Policy* 13(3) (2008), pp. 178–184.
76. S. Carr, *Personalisation: A Rough Guide* (London, UK: Social Care Institute for Excellence, 2012), p. 2.
77. See, L. Davidson, 'Recovery, Self Management and the Expert Patient: Changing the Culture of Mental Health from a UK Perspective', *Journal of Mental Health* 14(1) (2005), pp. 25–35.
78. S. Carr, 'Personalisation: An Introduction for Mental Health Social Workers', in P. Gilbert, ed., *The Value of Everything: Social Work and its Importance in the Field of Mental Health* (London, UK: Jessica Kingsley, 2010).
79. Department of Health, *Independence, Choice and Risk: A Guide to Best Practice in Supported Decision-Making Executive Summary* (London, UK: Department of Health, 2007). See also, Department of Health, *Putting People First – Working to Make it Happen: Adult Social Care Workforce Strategy – Interim Statement* (London, UK: Department of Health, 2008).
80. In March 2012, the Association of Directors of Adult Social Services Personal Budgets Survey showed that the total number of personal budgets delivered by local authorities across England is estimated to be 432,349, which is an increase of 38% in 2010–2011. The amount spent on personal budgets in 2011–2012 was nearly £2.6 billion some 15% of all direct spend on adult care and support services, ADASS, *Personal Budgets Survey March 2012: Results* (London, UK: ADASS/Judgement Framework, 2012).

designed care plans.[81] For many, creating a care plan and then organising providers to meet these identified needs is a challenging task to undertake alone. In practice, patients are encouraged to work with clinicians and social care staff to facilitate implementation.[82] When a plan has been formulated, social care support can be obtained from a variety of sources, including statutory social services, the private sector, the voluntary sector, community groups, neighbours, family and friends. For those who need it, assistance in devising a care plan reflective of individual need is an essential element of the process; particularly as individual budgets are increasingly being used as a vehicle to combine several funding streams that many mental health patients may need to access in the community. Payment for local authority adult social care falls within the remit for individual budgets and include integrated community equipment services, disabled facilities grants, Supporting People for housing-related support, Access to Work and the Independent Living Fund.[83] Glendinning's[84] research into the effectiveness of pilot schemes conducted by the Individual Budgets Evaluation Network demonstrates some promising results for patients, whereby clear benefits can be achieved through greater choice and control over funding. However, to enable mental health patients and other chronic patients with complex social care needs to benefit from this, better integration of services and a collective willingness to embrace choice needs to be fostered.[85]

How successful the personalisation agenda and its implementation under the HSCA 2012 is, is perhaps best judged by assessing the benefits to patients that have flowed from this agenda. Existing research already indicates that the injection of choice and control over care options can be very positive for patients and carers

81. ADASS, *Making Progress with Putting People First: Self- Directed Support* (London, UK: DH/ADASS/IDeA/LGA, 2009), see pages 3–4; See also, ADASS, *Personalisation and the Law: Implementing Putting People First in the Current Legal Framework* (London, DH/ADASS, 2009).
82. See, *Putting People First Consortium Advice Note (January 2010): Personal Budgets: Council Commissioned Services* (London, UK: Department of Health, 2010); *Putting People First Consortium, Briefing Note (January 2010): Personal Budgets: Managed Services* (London, UK: Department of Health, 2010); *Putting People First Consortium The Future of Social Work in Adult Social Services in England: Statement* (London, UK: Putting People First consortium, 2010).
83. Social Care Institute for Excellence (in collaboration with the AMHP National Leads Network and the Social Care Strategic Network for mental health), *Personalisation Briefing: Implications for Community Mental Health Services* (London, UK: SCIE, 2009).
84. C. Glendinning, *The National Evaluation of the Individual Budgets Pilot Programme* (York, UK: SPRU, University of York, 2008); C. Glendinning, H. Arksey, K. Jones, N. Moran, A. Netten and P. Rabiee, *The Individual Budgets Pilot Projects: Impact and Outcomes for Carers* (York, UK: Social Policy Research Unit, 2009).
85. N. Moran, C. Glendinning, M. Stevens, J. Manthorpe, S. Jacobs, M. Wilberforce, M. Knapp, D. Challis, J-L. Fernadez, K. Jones and A. Netten. 'Joining Up Government by Integrating Funding Streams? The Experiences of the Individual Budget Pilot Projects for Older and Disabled People in England', *International Journal of Public Administration* 34(4) (2011), pp. 232–243.

alike.[86] However, there is also evidence suggesting some groups may not be experiencing these benefits, notably, patients with mental health conditions, patients with dementia and other capacity-reducing conditions.[87] Bureaucracy and cuts in social care spending are exacerbating the situation; patients who require significant levels of support in this process may find their experience of the personalisation agenda hampered. Other associated and recurrent problems exist within the mental health system, placing further strain on the achievement of the personalisation agenda. For example, staffing shortages and service scarcities often result in extensive waiting times and inadequate response rates.[88] As such, staffing challenges and the need for extra support by mental health patients to benefit from the personalisation agenda may in reality make this policy a largely spurious one with little practical substance.

Conclusion

The HSCA 2012 represents a significant departure from a culture of public service provision that we have become accustomed to, but does it fail the vulnerable, notably those with mental health care needs? The need to drive efficiency up, whilst also tailoring health and social care to individual patients is, perhaps, an impossible dilemma.[89] Making systems responsive to individual need also raises the spectre of cost and waste; meeting the 2012 Act's expectations will be an exacting challenge and not for the faint-hearted. How mental health provision will fare in this new and uncharted landscape remains open; but, inevitably, it will face its own set of problems in the months to come. Does the 2012 Act fail the mentally vulnerable? Time will tell, though the tensions that exist between three of the key policy drivers within the legislation, the focus of this article, suggest that where there are pressure points and the vulnerable may ultimately experience the greatest detriment. Competition principles within the health and social care system may drive efficiency up. However, they cannot be responsive to the more nuanced needs of patients with chronic conditions,

86. C. Glendinning, *The National Evaluation of the Individual Budgets Pilot Programme* (York, UK: SPRU, University of York, 2008).

87. Association of Directors of Adult Social Services, Personal Budgets Survey March 2011, Available at: http://www.thinklocalactpersonal.org.uk/_library/ADASS_Personal_Budgets_Survey_March_2011_-Summary_of_Results_9.6.11_3.pdf; Think Local, Act Personal Partnership, Personal Budgets Outcome Evaluation Tool (Poet) Survey, June 2011. Available at: www.thinklocalactpersonal.org.uk (accessed 23 June 2013).

88. See for example, R. Kakuma, H. Minas, N. van Ginneken, M. Dal Poz, K. Desiraju, J. Morris, S. Saxena and R. Scheffler. 'Human Resources for Mental Health Care: Current Situation and Strategies for Action', *The Lancet* 378(9803) (2011), pp. 1654–1663; G. Aarons and A. Sawitzky, Organizational Climate Partially Mediates the Effect of Culture on Work Attitudes and Staff Turnover in Mental Health Services, *Administration and Policy in Mental Health and Mental Health Services Research* 33(3) (2006), pp. 289–301.

89. A. Woolridge, A. Morrissey and P. Phillips, 'The Development of Strategic and Tactical Tools, Using Systems Analysis, for Waste Management in Large Complex Organisations: A Case Study in UK Healthcare Waste', *Resources, Conservation and Recycling* 44(2) (2005), pp. 115–137.

particularly where care needs bridge both health and social care and are often required for lengthy periods of time.

Perhaps, the brightest ray of hope should be the recognition that parity between mental and physical health will be a clear objective.[90] As with so many of these things, effective policy needs to be translated into a workable and user-friendly legal framework that can then be implemented. In mental health, it is the implementation stage that frequently presents the most significant challenge for decision-makers, with limitations in staffing, funding and social care placements creating bottlenecks in the system. Unless these practical hurdles can be overcome, the desire to forge a new and fairer culture within health and social care, where parity between mental and physical health is the accepted benchmark, will be a very difficult one to attain.

The HSCA 2012 offers a very real opportunity to enable mental health to be mainstreamed into core public health priorities. But, this relies upon a determination reminiscent of Aneurin Bevan, 'The NHS will last as long as there are folk left with the faith to fight for it'. It can only be hoped that there are those prepared and willing to *fight* to ensure the needs of vulnerable groups, such as those with mental health conditions, are met and protected and that *faith* in the achievement of health and social care equality endures.

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90. P. Cunningham, 'Beyond Parity: Primary Care Physicians' Perspectives on Access to Mental Health Care', *Health Affairs* 28(3) (2009), pp. 490–501.